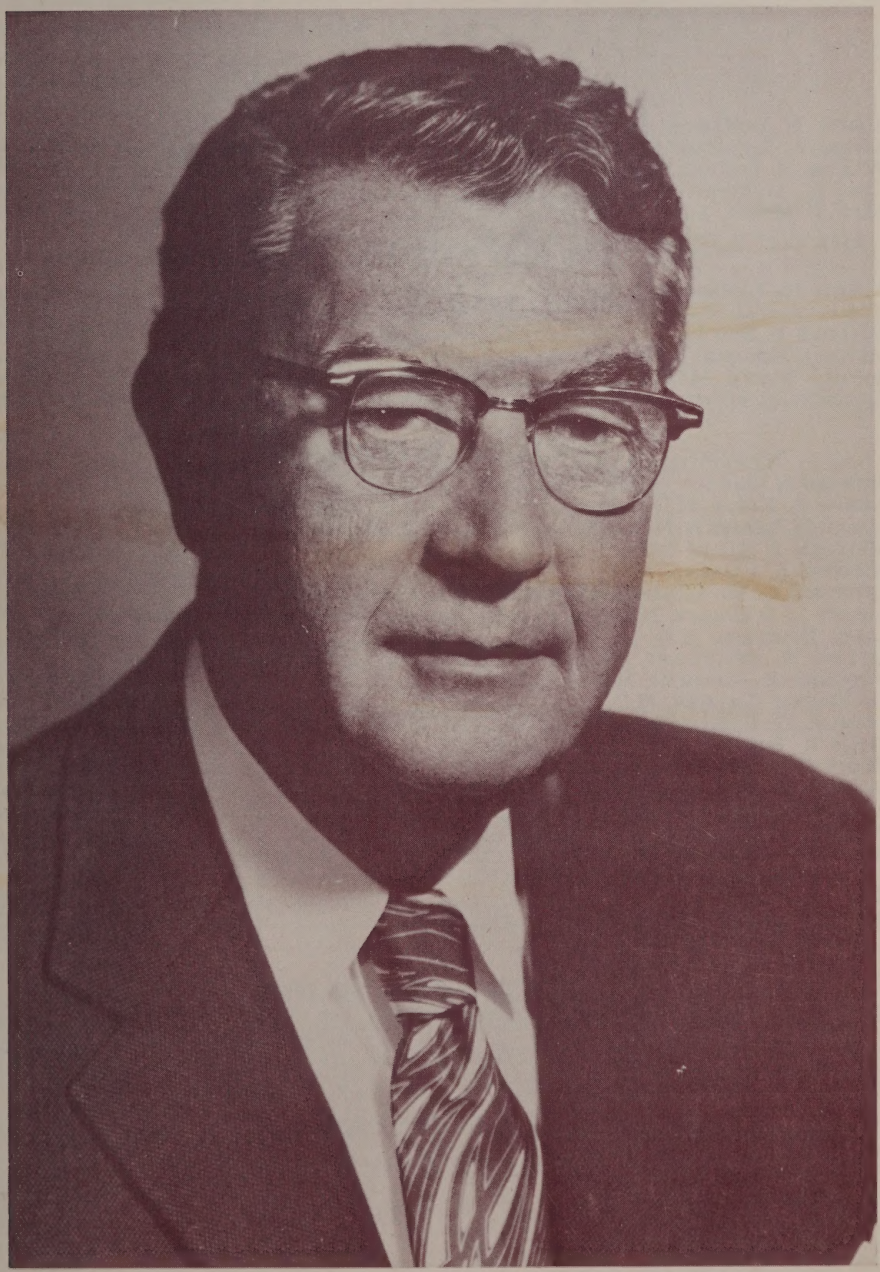
The Hampden Hippocrat

January
1973



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A bulletin for
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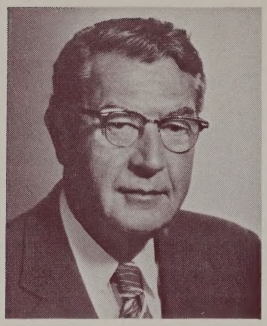

A MESSAGE TO THE HAMPDEN DISTRICT MEDICAL SOCIETY

from
CARL A. HOFFMAN, M.D.
PRESIDENT, AMA

(Editor's Note – The following remarks were made by Dr. Hoffman to the AMA House of Delegates meeting in Cincinnati on November 26-29, 1972, and were the basis of his talk to the HDMS on December 5, 1972.)

What impressed me most, as I toured the Soviet Union, Great Britain, Sweden, and West Germany for five weeks this past summer, was the fact that the health care problems of the United States also are to be found in these other nations where economic, political and cultural conditions are so different from our own.

Despite the outcries of our critics, we *must* recognize that the people of the United States enjoy the highest *quality* of medical care to be found *anywhere* in the world. But we also must recognize that, despite the high quality, there are other areas of health care which must be improved.

Two of these problem areas, I found, are common to the United States and to those countries which I visited recently.

One of these is maldistribution or shortages of physicians and other health care personnel which limit access to medical care for some citizens, and extended waiting periods for some types of care.

But perhaps even more important, my survey of health care in four European countries indicates to me that we in the United States appear to be sadly deficient in insurance coverage for catastrophic illness. Our insurance companies have made excellent progress in this area, but it is my opinion that not enough has been accomplished. No one in this affluent nation of ours should suffer financial deprivation or bankruptcy because of serious illness or accident.

CATASTROPHIC COVERAGE

I believe that catastrophic coverage, based on a broad comprehensive program of health care financing, should be one of the major goals of our medical profesion.

I have been told by insurance executives of the many difficulties inherent in attempting to provide such coverage. I have been told there would be insoluble problems, especially that of abuse. I have a suggestion which may resolve one of those "insoluble" problems.

Some industry spokesmen have said that my solution is unworkable, but it seems to me to be a simple and clearcut answer to the question of abuse. I suggest that, to avoid abuse, a number of conditions be specified as catastrophic – hemophilia, stroke, severe burns, severe accident injury, renal dialysis, for instance – and perhaps certain stipulations could be made to provide coverage for unforeseen or extremely unusual situations. I cannot believe that this is not workable.

PHYSICIAN MALDISTRIBUTION

Turning to the problem of maldistribution of physicians, one of the serious aspects, which seems to have no immediate solution is access to health care for Americans in the ghettos, or slum areas of our cities. I believe that one of the primary obstacles to proper health care for residents of these areas is crime – the senseless violence which

deters the physicians as well as the TV repair man, the delivery man, and, yes, sometimes even the police from entering these areas.

It is possible that part of the solution may lie in the neighborhood health centers with proper security measures – guards, fenced parking lots, and other precautions designed to protect the physician and health care workers.

Accessibility to health care also is a problem in some of our rual areas, and in isolated geographic areas such as the Appalachian Mountains. But it is as great a problem in the countries which I visited – countries comprised of much smaller areas and fewer people. The problem appears severe in Sweden, and moderately severe in England. It is evident in Germany, where the population equals the combined census of New York, Pennsylvania, Illinois and California, all crowded into a geographic area only slightly larger than Idaho.

It is interesting that even in the Soviet Union, where the government has rigid control over medical practitioners, it has been necessary to offer incentives to hold physicians in isolated or rural areas after they have completed their assigned three year tour of duty by which they repay to the state the cost of their education.

In Sweden, a country no larger than our state of California, it is difficult to provide medical services to a rural area less than 100 miles from Stockholm.

In England, to ease this problem, the government has followed the course we found in Russia. Certain incentives, such as a heavier load of assigned patients and thus more income, are being used to attract physicians into sparsely populated parts of the United Kingdom.

The distribution of health manpower in the United States is improving, in my opinion. We gradually are making care accessible to people in areas where there has been little or none available in the past. But I believe we are not moving fast enough. We must find ways to entice physicians into rural areas, and perhaps even make it almost *mandatory* for physicians to practice in the smaller communities and less populous areas of our country. Many of these are delightful places to live and to work, and I am convinced that many physicians would be happy professionally and personally, after they became established.

POSSIBLE SOLUTION

Many of our medical societies and associations as well as other groups already make educational loans to needy medical students, often with the provision that repayment will be waived if the student agrees to practice in a designated area where a physician is needed. These programs, while commendable, have met with limited success primarily because the young physicians often elect to practice in the location of his choice, and they repay the loan, instead of fulfilling his original agreement.

I have interviewed many prospective medical students, young men and women who

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are strongly motivated and highly qualified, but financially unable to afford the high and growing costs of medical education. I have seen them progress through their medical training plagued by mounting debts, and I have watched their idealistic desire to serve the poor, the underprivileged and the disadvantaged gradually change to a more practical viewpoint as they realize they must earn enough income, as rapidly as possible, to pay off their debts and to provide for their families.

I suggest that we can aid deserving but poor students, and in part solve our physician maldistribution problem, by offering an alternative to the student of limited means.

I see no reason why, under a strictly voluntary program, the student could not be given the opportunity to obtain his education under state or Federal financing, by entering into an unbreakable contract which would require him to practice in a needy area for three or four years in order to discharge his debt. He would not have the option of cash repayment. I emphasize that this would be a voluntary action.

Many of you may believe that this is too much like the highly regimented Russian system, under which the new physician must go to an assigned area for a specified time.

My suggestion only superfically resembles the Russian program, since it is based on a purely voluntary agreement by the student.

The obvious question, of course, is: How would such a program be controlled?

The solution seems simple to me. Medical societies and licensing boards, working together, would agree to give the new physician a temporary license permitting him to practice *only* in a designated community or area. Then, at the completion of his obligatory period of service, he would be granted complete licensure.

This proposal admittedly is a drastic change from our previous concepts but I ask that before you condemn it, consider it and consider it carefully.

PROBLEMS AND CHALLENGES

Let me refer to the wise words of J. Enoch Powell, former Minister of Health, a member of Parliament, and a critic of England's health care scheme. "Any service which is available to the consumer must have at least one of two controls – either monetary or a waiting period."

Mr. Powell has also commented that one cannot compare the health care systems of countries – the United States and the United Kingdom, Sweden and Russia, and so forth.

But we can compare selected programs, policies and problems. We can measure them against each other to see what has succeeded and what has failed.

When we consider the great differences between the peoples, the governments, the cultures and the socio-economic systems of various countries, we see the impossibility

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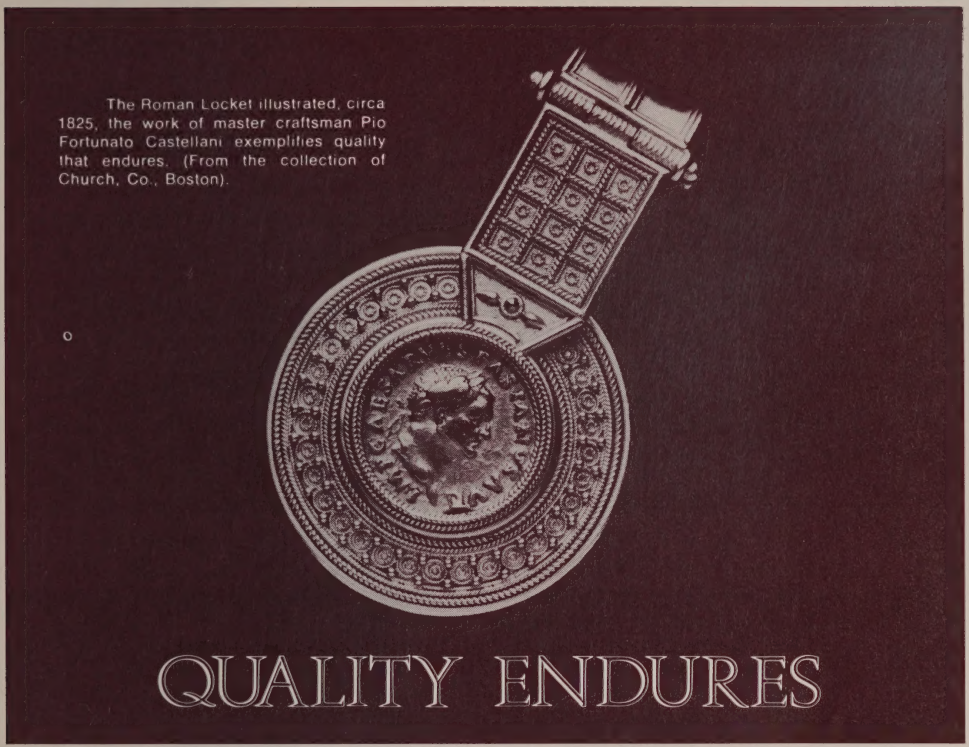
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and the fallibility of comparison. We cannot compare the United States – with more than 200 million men, women and children, and uncounted cultures – with Sweden, a nation about the size of California, with a largely homogenous population scarcely greater than that of New York City. We must remember, for instance, that Sweden has only one minority group – about 50,000 Laplanders – in a total population of about eight million.

Despite these formidable differences between our own United States and the countries I visited, one can draw upon their experiences in an effort to solve our problems.

Now, let us look at our problems as challenges.

One of the greatest challenges facing the medical profession of the United States is making health care easily accessible to every man, every woman and every child.

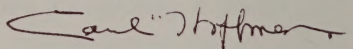
The AMA is on record as firmly believing that every American has the *right* to access to health care. Nonetheless, it is estimated that from five to twenty percent of our people do not have this access. There are many reasons for this. Some do not know how to get care that may be available to them; while others, living in isolated areas, may not know how or may not be able to get to available care. From my own experience I know of families in isolated, mountainous areas of Kentucky and West Virginia who have not signed up for Medicare, Medicaid and other programs because they are unable to get to the office or the authority whereby they can sign up for coverage. I doubt if we can even attain 100 percent accessibility, but this does not mean we should not try.

Despite the imperfections in our health care system, most of the world looks to the United States as the epitome of health care quality. Now we must work to solve two serious problems – failure to provide financial assistance for our citizens who face the astronomical costs of catastrophic illness and failure to make quality health care reasonably accessible to all. We can solve these problems, and we may find the solution by looking to our colleagues in Europe – by discarding those programs which have been ineffective in the countries I visited and by adopting or adapting those programs which have been successful.

I must emphasize that every country has its dissident groups among the public, the hospitals and the medical profession.

Even in West Germany, which on the surface has one of the best health care delivery systems in Europe, I found the people complaining about long waiting periods. I also found organized labor hoping to divert laboratory services from the private practitioner into a system where such services would be carried out in the hospital – as in England – or in a network of controlled laboratories. I was told this change has been sought under the guise of lowering costs.

But when I asked an official of the German Medical Association if physicians were happy, his answer was: "Is everyone ever happy?" Moreover, he went on to say, "We have complaints, we have problems, but the members of the medical profession enjoy the highest income of any profession or group in West Germany."



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26th AMA CLINICAL CONVENTION

CINCINNATI, OHIO
NOVEMBER 26-29, 1972

(Editor's Note – The following are highlights of actions of the AMA's House of Delegates meeting as issued from the office of the AMA's Executive Vice President.)

The AMA will "provide a dominant role of leadership in the implementation of the PSRO program to assure that the best interests of the public and the profession are preserved," the House of Delegates decreed, in acting on the major issue at the 1972 Clinical Convention. This will be done by creating an Advisory Committee on Professional Standards Review to help provide input from the medical profession in development of PSRO regulations, and to help constituent societies set up PSRO's, among other things.

On other matters, President Carl A. Hoffman offered bold suggestions on solving the problems of catastrophic illness insurance coverage for Americans and the maldistribution of physicians. And delegates gave their approval to budget restraint measures within the AMA.

Meeting for a total of 8 hours and 55 minutes, the House acted on 59 reports and 65 resolutions, the greatest total number of measures presented at a clinical meeting in several years.

PSROs

The AMA will "provide a dominant role of leadership in the implementation of the PSRO program to assure that the best interests of the public and the profession are preserved," the House decreed, in adopting Report Z of the Board of Trustees and the Council on Medical Service. The issue of PSRO – Peer Standards Review Organization – was No. 1 at the convention.

A lengthy plea by one delegate that the House defer action on Report Z – which he called a "complete reversal of our policy" – was rejected. Report Z noted that while PSRO legislation was pending in Congress, the AMA questioned whether its emphasis on cost control might not lead to a lowering of the quality of medical care. But since it is now law, the report said, AMA should act to guard the interests of the public and the profession.

An AMA Advisory Committee on Professional Standards Review will be created by the Board of Trustees. It will include members of the Board and Council on Medical Service. In addition, the Board may invite other appropriate organizations to participate.

Among responsibilities of the Committee are these:

1. To provide input from the medical profession in the development of rules and regulations which will govern the PSRO's program.

2. To assist state medical associations, or state medical associations in concert with county societies, in developing PSROs and to recommend structures and operating mechanisms for such organizations.

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3. To aid in defining appropriate geographic boundaries for PSROs, especially where more than one state may be involved.

In addition to the eight areas of responsibility outlined in Report Z (including the above) floor amendments added several more which would have the Committee:

Develop and distribute information about PL 92-603 to constituent societies; monitor the effect of PSRO on medical care, and report to each future House session; and instruct the House and state societies on procedures to follow "whenever rules and regulations interpreting the law and published in the Federal Register seem to be contrary to the spirit of the law as written."

FISCAL RESTRAINT

A summary of the 1973 AMA budget, prepared by the Office of Finance and the Finance Committee, drew congratulations from the reference committee which studied it. And budget-cutting action recently taken by the Board of Trustees was approved by the House.

"In considering the budget for 1973, the Board of Trustees made a determined effort to exercise fiscal restraint, and to allocate our financial resources according to priority needs," the Board said in Report A. The budget summary anticipates 1973 gross revenues of just over $37 million and operating expenses of $36,322,000, leaving a projected surplus of about $800,000.

Fiscal restraint action taken by the Board included the termination of four councils and six committees. One resolution sought to rescind termination of the Council on Drugs, but the House instead adopted a substitute resolution. That measure says the Board shall continue to use "all appropriate AMA resources and methods indicated, to the point of establishing a committee, if necessary, to delineate clearly the independent AMA policy on drugs and drug therapy."

Another economy action was making specialty journals available on subscription only, starting Jan. 9. *Prism*, the AMA's new socio-economic publication, will be sent as a membership benefit, along with JAMA.

TERMS OF TRUSTEES

As authorized at the 1972 annual meeting, House members balloted on the question of terms of office of board members.

At present, trustees serve 3-year terms, with a maximum of 3 terms. Eighty-nine delegates voted to continue this policy but the majority, 128, voted for a maximum of only two 3-year terms. There were 14 votes for 2 terms of 4 years each, and 6 votes for a single 6-year term of office. The matter was referred to the Council on Constitution and Bylaws for study and possible recommendations.

MEDICAL CARE OF THE POOR

Since the House in 1971 urged creation of state and local medical society committees concerned with health care of the poor, 23 state and 29 local societies have set up such panels. And they are now developing programs to improve health care services. This progress note is included in Report G of the Council on

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Medical Service, which the House urged be given wide distribution. The report emphasized that local systems must be developed to meet local needs.

On related measures, the House urged organized medicine to continue to provide assistance and work to improve the quality of care in free clinics, which are increasing in number around the nation. Currently, there are more than 200 of them in 30 states.

They provide a variety of services and, as the report approved by the House points out, for those people who might not otherwise receive *any* health care, they are filling a real need.

The House also approved a statement on the concept of health outreach, whereby lay workers serve to bridge the cultural gap between patients, professional staff and the community, and assist in effective delivery of health care. Among several sound reasons for using such workers, the report says, is that they free doctors and other health professionals to better utilize their time and thus extend the scope of their services. The statement recommends that the AMA, state and local medical societies encourage the use of such personnel, and that the AMA institute educational activities for physicians and other health professionals on the use of outreach workers.

BLOOD BANKS

The House adopted Report N of the Board, which deals with new federal regulations in regard to collection and distribution of blood. Among the recommendations to be given to a federal panel on blood banking are:

That operating standards of the American Association of Blood Banks and the American Red Cross be recognized and accepted; that physicians be represented on any national panel set up to advise on procurement or use of blood, and that programs to increase voluntary blood donation be encouraged.

YOUNG PHYSICIANS

The Council on Long Range Planning and Development will be expanded to include one intern and resident member of the AMA as a full voting Council member, the House decided. That member is to be appointed by the Speaker of the House, who subsequently announced that he intends to name Dr. John Mather of the University of Maryland Hospitals, out-going chairman of the Interns and Residents business session, to the post.

Proposals to appoint an intern or resident to the Councils on Medical Education and Medical Service were deferred for further study, and the Council on Constitution and Bylaws directed to offer specific recommendations for action at the 1973 annual meeting.

For the first time in the history of the AMA, a medical student took his seat in the House of Delegates. He is George Blatti of Minneapolis, a senior medical student at the University of Minnesota medical school. In another action, the House set annual dues for student AMA members at $15.

ISR RULING

The House was informed that an Internal Revenue Service ruling – which barred physicians from withdrawing voluntary contributions to their Keogh Law plan prior to disability or age 59½ – will be revised to permit withdrawal of such contributions made to a qualified plan prior to March 6, 1972. The AMA had vigorously protested the ruling, and delegates complimented AMA staff for its "prompt and effective action."

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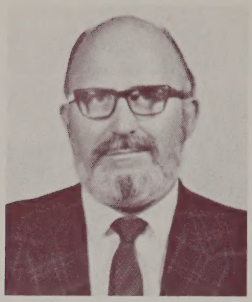

President's Page

JOIN!

Recently, I had the pleasure of spending some time with a very fine gentleman, namely, Dr. Charles A. Hoffman, President of the AMA, whom I found to be extraordinarily adroit, perceptive, and yet, humble. His entire concern was to see that, number one, the patients receive the best possible care, and number two, that the physicians are kept in their proper professional status to render such care. He and I discussed many points, and we both were definitely in agreement relative to medical care for catastrophic illness which should be governmentally controlled and subsidized inasmuch as no one, even the wealthy, can very well sustain a prolonged period of illness in any of the present day hospitals or even nursing homes because costs are so great.

Furthermore, we discussed the need for the local physicians to carry out their own peer reviewing, particularly under HR1 as recently passed in Congress on October 17, 1972, signed by President Nixon on October 21. We have until the first of January, 1974, to come up with at least 300 physicians representing the entire area and so qualify as the professional standard review organization.

The immediate step, as you know, is to review the Medicare and Medicaid work. It will not be long before the PSRO extends its tentacles to review all the work in the hospital on all cases, and also, into one's office on all cases.

Therefore, I am making a fervent plea to the members of the medical profession in our Society, the osteopaths, dentists and other medical people to get the Foundation going. As soon as we reach the level of 300 members, we then can make our application to the HEW to become the PSRO for the Western Massachusetts area. If the medical profession does not wish to do its own peer review work, then all I can say is that we will meet the expectation of people in government who feel that we will fail. I wish to be able to prove them wrong for once by having the necessary membership. We will show them that we will peer review ourselves, and we will do a fine job. This will keep the patients, the government, and, I hope, the physicians happy. Your committees worked hard and long last year to get this organization going. The present Board of Directors is working hard and assiduously trying to get the membership up. We have met with hospital administrators and the labor unions, and by the time this message reaches you, we should have also met with the insurance companies. We have two more major groups to meet with, namely, management and then consumer groups. We are doing our part, and all we ask of you is to do your part by joining the Foundation as quickly as possible so that we may reach the magic number of 300 and apply for becoming the PSRO for Western Massachusetts.

Robert N. LaMarche M.D.

Robert N. LaMarche, M.D.

NEXT MEETING
of the
HAMPDEN DISTRICT MEDICAL SOCIETY

TIME:	Tuesday, February 6, 1973 Business Meeting at 6:00 P.M., followed by Social Hour at 7:00 P.M. Dinner
PLACE:	Baystate West Motor Hotel, Ballroom 1500 Main Street Springfield, Massachusetts
COST:	Physicians and wives invited to attend. Per person – $7.20. Checks must be sent in by February 1, 1973
SPEAKER:	W. P. Loh, M.D., Ph.D. Methodist Hospital of Gary, Indiana
TOPIC:	"Acupuncture and Medicine Around the World"

YOUR PRESENCE IS URGENTLY REQUESTED

Walton E. Stevens M.D.

Walton E. Stevens, M.D., Secretary, HDMS

HDMS DECEMBER MEETING HIGHLIGHTS

The December meeting of the HDMS was held at the Highpoint Motor Inn, Chicopee, on December 5, 1972, in conjunction with the Springfield Academy of Medicine. In attendance were 104 physicians (10 attending without reservations); reservations: 140, (46 reneging on reservations).

The meeting was called to order by President Robert N. LaMarche at 6:25 P.M. with the first order of business being the minutes of the September 26, 1972, meeting, which were accepted as read.

Dr. LaMarche reported briefly on the recent HCFWM's meeting with local hospital administrators and Dr. H. Thomas Ballantine, Jr., of The Commonwealth Institute of Medicine. He emphasized the importance of physicians joining the HCFWM in the light of the recent enactment of the PSRO legislation. He thereupon called on Dr. Donald R. Hayes, MMS's delegate to the AMA's House of Delegates, to discuss the events pertaining to PSRO's that transpired at the Clinical Convention held in Cincinnati the previous week. Dr. Hayes reported that after opposing any schemes of federally mandated peer review for the last few years, the delegates voted a restrained approval of the concept and established a PSRO Advisory Committee. He stressed the fact that PSRO's are going to have a major effect on the practice of medicine and its organizations. Moreover, the AMA intends to help in HEW's development of the regulations implementing the law. Peer review can only be done by physicians; hence, the AMA intends working with the federal government, state and local medical societies, foundations for medical care, and others in setting up PSRO's. Physicians must be doing peer review of institutional care for Medicare and Medicaid programs under the aegis of an approved PSRO by 1976; otherwise, the government will do it. Dr. LaMarche pointed out that the HCFWM could meet the requirements of an approved PSRO. Since a minimum of 300 participating physicians is needed, he strongly urged the area physicians to join.

The members next approved the Medico-Legal Code as agreed upon by the Executive Committees of both the HDMS and the Hampden County Bar Association. The draft of the code appeared in *The Hampden Hippocrat* of April, 1972, but was accepted by both organizations only after a modification wherein paragraph C. of Section I was

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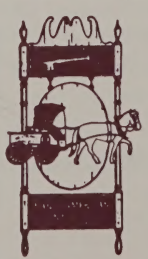

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stricken and the following substituted:

"C. In those cases where the physician is the attending physician, if the request for the report is received while the patient is still being treated, or soon after treatment is completed, the charge made by the physician for the report shall be commensurate for the time in preparing such report, but it shall not exceed $25.00 unless a higher fee has previously been agreed to by the lawyer and physician after consultation."

Dr. Robert N. LaMarche's selection to represent the HDMS on the Board of the Commonwealth Institute of Medicine was approved.

Dr. James D. Allan introduced the following resolution pertaining to Mass. Blue Shield, Inc.:

"Whereas, Massachusetts Blue Shield, Inc. continues to use regional profiles in its statistical calculation of fees in both its own Usual and Customary Plans and under the Medicare program;

Resolved, that the Executive Committee of the MMS meet with the proper officers of Blue Shield and Arthur D. Little, Inc., to negotiate an agreement as to the proper regions to be used in statistical commutation of fee profiles;

Be it further resolved, that the Committee file its report with the Council by the next meeting and that future changes in said regions shall be negotiated rather than left to the discretion of Blue Shield;

Be it further resolved, that any negotiated agreement does not rescind the previous vote of the Council that the Commonwealth should be treated as a single region, but does recognize the reality of Blue Shield's present methods."

The membership adopted this resolution which is to be forwarded to the MMS for appropriate action.

The meeting was recessed from 7:05 P.M. to 8:20 P.M. for a social hour and a collation. Upon resumption of the meeting, Dr. LaMarche introduced Dr. Carl A. Hoffman, President of the AMA, who made a stimulating presentation (see page 4).

After a brief question and answer period, the meeting was adjourned at 9:20 P.M.

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TUESDAY, FEBRUARY 13, 1973

SPEAKER: Roman W. DeSanctis, M.D.
Department of Medicine
Cardiac Unit
Massachusetts General Hospital

TOPIC: "NEW APPROACHES TO NONARRHYTHMIC COMPLICATIONS OF MYOCARDIAL INFARCTION"

PROGRAM Clinic 5:00 P.M., Springfield Hospital Medical Center
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* Formal Lecture, 8:00 P.M. at the Storrowton Tavern, West Springfield

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A PROJECT IN SEARCH OF A BOOK SHELF

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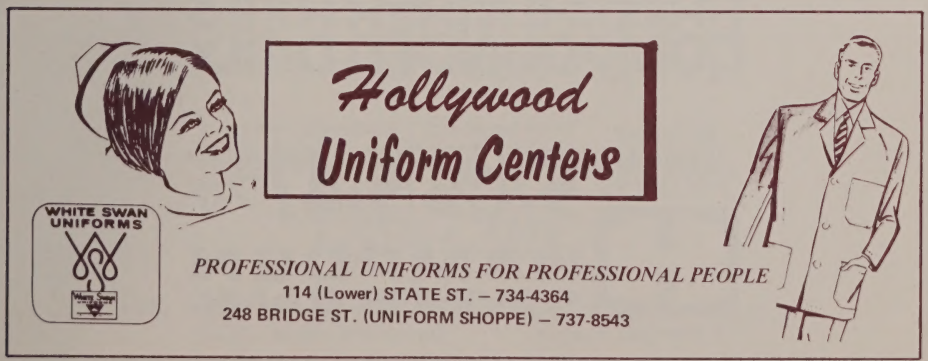
– Hippocrates

The situation at the library of the Springfield Academy of Medicine, wasn't much better. Mrs. Lund, always gracious and courteous, explained that the only pertinent material on the shelves at the Academy library were copies of *The Hampden Hippocrat* and of the *American Medical News,* donated weekly by a benevolent member. Yes, she does get requests for other socio-economic material. What about establishing a special section or at least a shelf or two for this type of literature? Yes, she'll be glad to bring this project to the attention of the Library Committee for consideration at its forthcoming meeting.

What publications, specifically, should fill the designated shelves? First of all, material dealing with health bills enacted or considered for action by our legislative bodies. In this respect the *American Medical News* (Capitol Hill), *The MMS Newsletter and The Hampden Hippocrat* (Beacon Hill), would well serve the purpose. Next, the shelves should include material descriptive of health care systems in foreign lands as compared with our own. In this category Mr. Schwartz's book takes first honors. Then, there is the need for works exposing quackery in all its forms. A good example is *At Your Own Risk,* a book dealing with the menace of chiropractic, distributed recently by the MMS. Last but not least, there is need for the dissemination of public health information as exemplified by *Fluoridation Facts,* a portfolio distributed last March by the Massachusetts Department of Public Health, and *The Case Against Hunger,* a very revealing book written not long ago by U. S. Senator Ernest F. Hollinger.

SOURCE OF MATERIAL

Practically all the references mentioned are available at little or no cost. The reason for stressing this point is to indicate that a library section on medical socio-economics would be neither difficult nor expensive to maintain. In addition to the prestigious *American Medical News,* the AMA publishes a long list of brochures obtainable on request or at a nominal fee. Then there is the AMA's Archive –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248 BRIDGE ST. (UNIFORM SHOPPE) – 737-8543

Library Department, ever ready to furnish, again on request, special material and reprints.

Additional material is obtainable from governmental agencies, such as HEW, the Surgeon General's office, the Food and Drug Administration and the Superintendent of Documents. Organized medicine at all levels would be more than willing to place the Academy Library on its mailing lists. Consideration might be given also to *Medical Economics, Private Practice,* the *Journal of the American Hospital Association,* and other paramedical publications.

Shortly after the last District meeting, our guest speaker, AMA's President Dr. Hoffman, was asked to comment on a recent book by Harry Schwartz entitled *The Case for American Medicine*(1). Dr. Hoffman praised it highly and indicated that the AMA is planning to publicize it as much as possible. He also expressed hope that state and district societies would follow suit and exert a similar effort in the same general direction.

Mr. Schwartz's book, incidentally, received a very enthusiastic review in the *N.Y. Times* of December 10, 1972. Quoting the reviewer:

"Not calculated to pander to critics of our medical system who prefer Utopian schemes, it deserves the widest possible reading by all serious students of the problem. Schwartz's thesis is simple: United States medicine is not so grievously ill as it is made out to be, and the radical social surgery proposed as corrective measures constitutes a cure that may be worse than the disease."

But "The case for American Medicine" is but one example of the inumerable books, brochures, pamphlets, and magazine articles published recently on the subject of medical socio-economics. As our problems multiply so do the publications proliferate. Only a short while ago terms such as HMO, Foundations, PSRO, and the Bennett Amendment, were unheard of; today, they have become an integral part of our everyday vocabulary. New concepts, new laws and a new terminologies are bound to come. The literature explaining their

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meaning and significance must be made available to all comers, physicians and laymen alike.

LIBRARY BROWSING

A search at the Springfield Public Library for material covering topics such as medical care systems, hospital costs, medicare, medicaid, and the like proved futile. The librarian's recommended index file, labeled "Hygiene," listed very little that was either social or economic on a medical sense, and most of that was on the archaic side.

The above, needless to say, constitute but a few examples of the tremendous literature available today in the field of medical socio-economics Like in the selection of all other publications the Library Committee undoubtedly will deem it wise to screen the newer material to make sure that it is authentic, logical and realistic. There is of course no sense in filling our shelves with books that lack candor or smack of literary quackery and political expediency.

It is sincerely hoped that the Academy in its wisdom will decide to designate shortly a library section for publications dealing with the political, social and economic phases of medicine. Moreover, a project of this nature is well deserving of the wholehearted support of the HDMS. We owe it to our profession, to the many students in this area and to the public at large, to place such literature within easy reach of all who are interested in using it.

(1) "The Case for American Medicine" (A Realistic Look at Our Health Care System) by Harry Schwartz. 240 pp. New York. David McKay Co. $6.95.

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MARK YOUR CALENDAR NOW!

HDMS Meeting, February 6
HDMS Executive Committee Meetings, February 20 and March 20
MMS Council Meeting, February 14
MMS Annual Meeting, May 29-31
American Academy of Orthopedic Surgeons, Las Vegas, February 1-6
American Academy of Allergy, Washington, D.C., February 10-14
American College of Cardiology, San Francisco, February 14-18
AMA Annual Meeting, New York, June 23-28

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HIGHLIGHTS OF THE DECEMBER EXECUTIVE COMMITTEE MEETING

The Executive Committee met on Tuesday evening, Dec. 19, 1972, in the Conference Room of the HDMS. Present were Drs. Stevens, Janovsky, Zacarian, Burke, LaMarche, Moore, Keroack, Cummings, Asinas, Bandeian, McHugh and Mrs. Purdy. Dr. Goldberg was absent.

President LaMarche called the meeting to order at 8:10 P.M.

The minutes of the November meeting were read by Dr. Stevens and approved by the Committee.

CORRESPONDENCE

Dr. Hirschhorn wrote complaining that after a number of years the Committee on Insurance, Labor Relations and Industrial Accidents still had not solved problems with the Aetna Life and Casualty, the Conn. General and other insurance companies. The Executive Committee suggested that a copy of his letter be sent to the AMA Council on Medical Service. It was also voted to invite Dr. Hirschhorn to the Foundation meeting in January when the Board meets with the insurance companies.

OLD BUSINESS

Dr. LaMarche appointed Dr. Keroack to chair the AMA membership drive. A membership kit is to be sent from AMA and this will help with the drive. Dr. Wanzer, chairman of the State Committee, will be notified of Dr. Keroack's appointment.

Dr. Stevens gave the result of the questionnaire which was sent to the membership with the last *Newsletter.*

Quoted as written:

1. I would like periodic business meetings to be held with no dinner. Yes 36

2. I would like to hold three business meetings per year with no dinner, but continue the Annual Meeting as a dinner meeting paid for by the Society. Yes 60

3. I prefer to keep the present system of four District Dinner meetings per year paid for by the Society. Yes 59

This will be presented to the membership in February for a vote.

A report of the Oral Cancer Detection Clinic was sent from STCC. The clinical findings were no treatment required – 44; treatment required, but not urgent – 40; urgent treatment required – 5.

At the Clinical Meeting of the AMA held in Cincinnati, the Council on Medical Service voted to request the following: "that the Council collect and accumulate data as presented by

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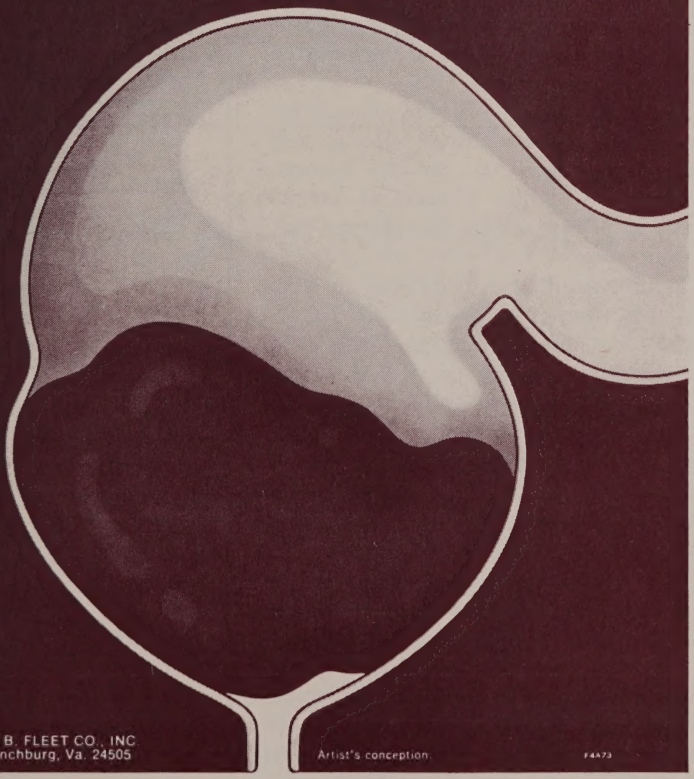

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individual physicians, county, state and constituent societies, to determine whether or not the affirmations of Aetna Life & Casualty representatives as cited in Report J are in fact being carried out and a report of this information be presented to this House at the Annual Session in 1973." Any complaints from any physicians should be sent to the HDMS for transmissal to the AMA.

Dr. LaMarche gave a report of the HCFWM, Inc. The Board of Directors met with the labor union representatives recently. The next meeting will be with insurance companies in January. There are presently 124 members.

Massachusetts Blue Shield, Inc., answered Dr. Stevens letter of October 5, 1972 concerning physicians' profiles. If a physician has any question about the process by which his profile is determined or the underlying data, he should contact Mr. Rufus Titus, Vice President of Professional Relations.

NEW BUSINESS

Dr. Zacarian had three suggestions of changes for the Executive Committee meetings.

1. Expansion of the Executive Committee. The Committee felt that, if it was any larger, it would become unwieldy. Also the Committee invites guests in at intervals as necessary to give reports.

2. Change of time of meeting to 7:30 P.M. The Committee approved of 7 P.M. for the Executive Committee meeting. It was voted unanimously that 7 P.M. would be the meeting time.

3. Mediation Committee instead of Grievance Committee and appointment of Chairman and members of committee. The Committee approved the new committee but disapproved of calling it the Mediation Committee. This necessitates a bylaw change and will be referred to the Bylaw Committee.

A Health Fair is to be held in Holyoke celebrating the Centennial of the City of Holyoke. Dr. O'Malley is the chairman of the fair and HDMS is to have a booth at the Health Fair. Dr. J. McHugh was appointed as chairman of the HDMS booth. The dates are April 16-19, 1973.

In order to inform the membership about the importance of PSRO, the Committee discussed the possibility of having a summary from the AMA sent to the membership. A price will be obtained and brought back to the January meeting for approval.

The Better Business Bureau asked if they could solicit the physicians for membership. The Committee approved of BBB sending information to the physicians about this organization.

Dr. Mills and Dr. Nessell have resigned from the Board of Editors of The Hamp en Hippocrat. The Committee accepted their resignations with regret. Dr. Ayres, the Editor-in-Chief asked if Dr. James D. Allan could be appointed as a member of the Board. The Committee approved.

The meeting was adjourned at 9:30 P.M.

The Grievance Committee met and heard four cases.

The meeting adjourned at 10:15 P.M.

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OUR ELDERLY

Most recently the Community Council of Greater Springfield put out *A Reconnaisance Report on the Aged and Aging Population of Greater Springfield.* This report contains interesting demographic data relating to our senior citizens, services and resources available to them, and a discussion of selected issues and programs. We shall quote extensively therefrom with an eye to stimulating interest and hopefully constructive action in regard thereto.

DEMOGRAPHIC DATA

"In the area including Springfield and the surrounding towns of Agawam, East Longmeadow, Hampden, Longmeadow, Ludlow, Westfield, West Springfield, and Wilbraham, there were 33,714 persons over 65 in 1970.

Over 60% of the population over 65 – over 20,000 persons – live in Springfield. The next largest elderly populations are in West Springfield and Westfield – about 3,000 persons each.

Most elderly in Springfield live in an area bordering the Connecticut River and the Chicopee Line. The heaviest concentration of total population is from State Street, south, and the heaviest concentration of poor, from Mill Street, north in Springfield.

One in twenty of those 65 and over live in institutions, primarily in Springfield. About one-third of the elderly are heads of households (predominantley male); another one-third (predominantley female) live alone.

The populations over 65 has increased by an average 25% everywhere but Springfield, where it has decreased slightly. In all areas, including Springfield, an increasing number and proportion of the elderly are older – ("over 70", "over 75", "over 80", and "over 85" age ranges are increasing steadily). In Springfield, the proportion and number under 70 is decreasing. Correspondingly, population from 50-70 is *increasing* in suburban areas.

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One in five Springfield elderly is at or below poverty income levels. One in three has an income no more than 25% above poverty levels. 65% of the Spanish-speaking elderly, and 30% of the Black elderly, have incomes at or below poverty levels.

Public housing in Springfield can accommodate less than ¼ of the elderly poor. The average rental payment for most of the elderly poor (Census tracts 8006-8012) in Springfield is $103-$126 per month – over ¾ of the average income.

Over 60% of the elderly in all areas are female. Over one-third of these are women living alone; about one-quarter are wives. More women live longer than men, and the proportion of women increases at higher age ranges.

Over 95% of the elderly are white. About 3% are Black, and less than 0.33% (110 persons) are other non-white. Over 90% (926 persons) of the Black elderly and 70% of the other non-white elderly live in Springfield."

PROBLEMS

As one reviews the listing of services available to the elderly in the Greater Springfield Area, one is impressed with the limited availability of same. What little is available consists primarily of institutional care, special housing facilities, and recreational activities. There are many problems facing our elderly, and some are most acute.

"At least 30% of Springfield's elderly exist 'at or near poverty'," as officially defined. Given the very low income levels at which these designations are officially applied, it is clear that many more than 30% of the elderly face chronic inadequacy of income.

Federal and State programs providing income for the elderly, given present eligibility and assistance levels, do not effectively address this problem. Current social security levels are not adequate to insure income security for the elderly despite recent increases.

Old Age Assistance (OAA) payments from the Welfare Department serve over 7,000 elderly in the Springfield area. The OAA payments of up to $189 per month are not sufficient to support an adequate standard of living for those over 65. Pressures to reduce overall Welfare payments at the State level are considerable; however, comparable

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payments for the elderly are at a higher rate than any other Welfare category.

The need for more adequate housing for the elderly continues to remain pressing in the area. Currently there are less than 900 units of public housing for the elderly managed by the Springfield Housing Authority.

Even this public housing is not effectively reaching the very poor.

At least 20% of Springfield's elderly occupy substandard housing units in the metropolitan area.

The average rental payment among the poorest elderly (census tracts 8006-8012) is $103-$126 per month. Along with high rent, poor maintenance and the danger of surrounding neighborhoods are frequent complaints from the elderly.

With a clear concentration of elderly in areas with predominantly older housing, and the generally poor condition of such housing in Springfield, it could be estimated conservatively that over 30% of Springfield's elderly live in housing which is either substandard or which needs repair to be suitable for elderly occupancy.

Over 5.6% of Springfield's elderly are institutionalized. According to a recent. Massachusetts study of public assistance recipients (1).

"a significant part of this institutionalization is not required by the physical condition of public assistance recipients and *that* it is resorted to for three reasons:

(1) the patient can no longer benefit from the services of the physician:

(2) alternative arrangements for care in recipients' own homes or neighborhoods have been lacking:

(3) a suitable State policy with appropriate administrative arrangements has been lacking through which the full spectrum of necessary services could be developed and appropriately applied."

For Massachusetts, a recent MDPH study of nursing home residents showed that "about 14% of the residents require no institutional care for medical reasons, and about 26%, little or no medical need for institutional care." (2)

Of those over 65 *not* currently institutionalized, nearly 13% report chronic disabling conditions which result in "inability" to carry out their major activity." (3)

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seriously underdeveloped and underutilized, partly due to problems of administration, definition, and funding of services especially under Medicaid and Medicare, and partly due to lack of services per se.(4)

The Community Council of Greater Springfield, Inc., priority study shows home meal services, homemaker services and home nursing services in need of development. Coordination and facilitation of a range of such services for elderly is not at present being attempted by any agency. Although MDPW social workers might, in theory, provide such services for recipients, in fact, large caseloads, and understaffing of the DPW effectively preclude any such involvement.

A detailed breakdown of medical care figures was beyond the scope of this study. However, it is recognized that medical care remains a major expense for the elderly.

Medicaid statistics indicate that $3 million dollars were spent on Medicaid payments in the Springfield office for January, 1972. 56% of these Medicaid funds are spent for the medical care of the elderly.

A frequent complaint is the lack of home health care as an alternative to hospital or nursing home care.

Transportation to medical facilities is a special problem for the elderly because of their dependence on public transportation or available relatives.

Facilities, or the lack thereof, is a major problem for the elderly poor – and a major problem to be overcome in designing any programs to serve the elderly. Problems of access to facilities is of crucial importance in designing programs for the elderly. A reduced fare system similar to the MBTA fare reduction should be explored.

Transportation is classified as a social service by HEW and therefore matchable at 75% under Title I of the Social Security Amendments of 1967. Various purchases of service arrangements are available and should be integrated into elderly service programs.

Elderly in Springfield's Brightwood section face a virtual absence of common services (shops, banks) within walking distance, and limited public transportation. Elderly living uphill from downtown also face severe physical hardships in carrying out routine errands."

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SOLUTIONS

It is quite obvious that our elderly have many problems. Except for some token talk, little seems to be going on in the way of coordinated planning and action. Some vigorous body is needed to make decisions on priorities as they relate to the needs, service delivery systems, and the procurement of funds for implementation. It is manifestly apparent that the elderly per se do not and cannot muster sufficient clout to pressure our youth oriented society into strong action on their behalf. Government at all levels has councils and agencies who purportedly are concerned with the problems of the elderly, but who manifestly can do no more than periodically beat their drums at such show pieces as White House Conferences and frustratedly wring their hands in between times. The aged are at the bottom of our society's list of priorities.

What are the alternatives in the solution of the problems of our elderly – vigorous action by all segments of our society with strong participation of physicians, if not leadership, in bringing about dignity to old age, or a slow evolutionary subconscious drift to some subtle or even nonsubtle forms of euthenasia?

Someone once said: "Don't resent growing old, for many are denied the privilege." Under the present circumstances the elderly may say: "If growing old is a privilege, neither we nor the young need or want it like it is."

(1) *An Alternative to Institutional Care for the Elderly and Disabled.* by Helen Kistin, Elizabeth Harris and Robert Morris. April 1971. Under the auspices of the Levinson Gerontological Policy Institute of Brandeis University.

(2) *Home Health Services in Massachusetts 1971. Their role in care of the long-term sick,* Elizabeth Harris and Robert Morris, July 1971. Livinson Gerontologist Policy Institute.

(3) *Personal Care for the Severely Disabled,* Francis Caro and Robert Morris, June 1971, Levinson Gerontological Policy Institute.

(4) Kistin, Harris and Morris, 1971.

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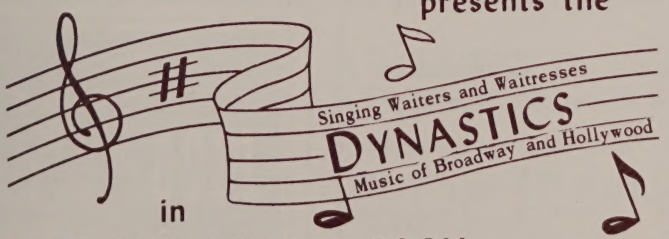

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THE PEDIATRIC NURSE PRACTITIONER

The Pediatric Nurse Practitioner has become an important element in the upgrading of medical care in Holyoke. Currently there are two Pediatric Nurse Practitioners working in the Model Cities Clinic and the Child Welfare Clinic, and two more nurses are in the process of enrolling in courses to become qualified for this new role of a nurse.

ORIGINS

What is a Pediatric Nurse Practitioner and how do they function? In the mid 1960's, Dr. Henry Silver of the University of Colorado in an attempt to relieve the shortage of pediatricians developed a program whereby highly motivated degree nurses were taught the elements of history taking and physical diagnosis and thus could serve in the role of a primary physician under the supervision of a licensed physician. Since then, the program has blossomed throughout the United States. In Massachusetts, the Mass. General Hospital in conjunction with the Bunker Hill Health Clinic and now Northeastern University has been running a training program for several years. Approximately 150 nurses have been trained in the Mass. General Hospital program and are now working in two main ways – in conjunction with private pediatricians and in neighborhood health clinics. It has been estimated that the three Pediatric Nurse Practitioners are equal to one pediatrician in their work productivity, and thus this new type of deliverer of medical care in complementing the physician's role in the Model Cities and Child Welfare Clinic.

HOLYOKE PROGRAM

Mrs. Phyllis Pheeney, the Pediatric Nurse Practitioner at the Model Cities Clinic in Holyoke, was the first nurse to enter the Mass. General Hospital course. Mrs. Pheeney is graduate of the University of Vermont Nursing School and has done public health nursing for eight years before joining the Model Cities Health Clinic. One of her nursing experiences was in the Dominican Republic, where she became fluent in Spanish, and this is a marked asset because many of the patients are from Puerto Rico and only speak Spanish. The course at the Mass. General Hospital was a four month one in which she spent one and a half days in Boston learning the fundamentals of physical diagnosis – how to use an otoscope and a stethescope, and how to take a history. The rest of the time was spent either in a preceptor's office or on the job where a preceptor would check out her diagnosis much in the same way an attending physician would check a medical student's workup. Mrs. Pheeney is now spending thirty

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hours a week at the Clinic and sees approximately eight children a day. She does well baby checkups on an alternating basis with the pediatrician who comes to three clinics a week at the Model Cities Clinic. Each clinic runs for two hours. When the physician isn't there, she examines the patients and determines if the patient needs to have further evaluation or if she can treat the patient herself. All her decisions to treat the patient by herself with medication are done with consultation by the pediatrician on call for the clinic that day.

The other Pediatric Nurse Practitioner is Mrs. Kathleen Sullivan who has worked as the infant care nurse at the Holyoke Child Welfare Clinic for over 20 years. Mrs. Sullivan, like Mrs. Pheeney, is able to speak Spanish, which she learned through taking evening courses at the Holyoke Community College Evening Division. A great deal of Mrs. Sullivan's work consists of making home visits to check infants who have been recently discharged from the hospital.

The Pediatric Nurse Practitioners, as they are being utlized in Holyoke, seem to be filling a largely unmet need; namely, bringing pediatric care to the area where the patients live. They appear to be highly accepted by those receiving the care. The physicians who work with these Pediatric Nurse Practitioners have been duly impressed by their competence and thankful for this extra hand in caring for the children in the city of Holyoke.

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